

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

UNITED STATES OF AMERICA,	:	
	:	
Plaintiff,	:	
	:	Civil Action No.
v.	:	
	:	
ABINGTON MEMORIAL HOSPITAL,	:	
	:	
Defendant.	:	

COMPLAINT

Plaintiff, United States of America, for its Complaint against Defendant alleges:

1. This action seeks damages and penalties under the False Claims Act, 31 U.S.C. §§ 3729-33, as amended, and the common law theories of payment by mistake and unjust enrichment as a result of the submission of over 70,000 claims for payment for outpatient clinical laboratory tests billed to the Medicare Program (“Medicare”) for the period 1991 through and including 1999. This is an action by the United States to recover approximately one million dollars in laboratory payments improperly claimed, received and retained by Abington Memorial Hospital (“Abington”) from the Medicare program.

In 1994, Abington was the subject of an audit by the Bureau of Program Integrity, Department of Public Welfare (“DPW”), of its laboratory billings to the Commonwealth of Pennsylvania. As the result of that audit, Abington Memorial Hospital was notified that certain laboratory billing practices were in violation of governing law and regulation, and was required to make restitution to the Commonwealth, with payment of the first installment in November, 1994, and final payment made in June, 1995.

Notwithstanding specific advice from the Commonwealth of Pennsylvania to Abington

that it had to submitted improper claims and received payment in excess of that to which it was entitled, Abington made no effort either to determine whether similar improper claims had been submitted to the Medicare program, to the Federal Employee Health Benefits program, to private insurers, or to citizens without insurance coverage for their laboratory bills.

Abington undertook no systematic review of its billing and collection practices to assure that they complied with applicable laws and rules, despite the 1994 Commonwealth of Pennsylvania audit, until 1998. Abington continued to submit laboratory claims for payments to which it was not entitled, and to receive payments to which it was not entitled until 2000. Abington continues to retain payments to which it is not entitled.

THE PARTIES

2. Plaintiff is the United States of America (“United States”) acting for the United States Department of Health and Human Services (“HHS”) and the Medicare Trust Fund.

3. The Defendant, Abington Memorial Hospital (“Abington”), is a hospital in Montgomery County, Pennsylvania located in the Eastern District of Pennsylvania. At all times relevant, Abington transacted business within the Eastern District of Pennsylvania and is subject to the personal jurisdiction of this Court.

JURISDICTION AND VENUE

4. This Court has jurisdiction over the subject matter of this action pursuant to 28 U.S.C. § 1345 and 31 U.S.C. § 3732.

5. Venue is proper in the Eastern District of Pennsylvania pursuant to 31 U.S.C. § 3732 and 28 U.S.C. § 1391.

THE MEDICARE PROGRAM

6. Medicare is a federal program created by the Social Security Act, as amended, 42

U.S.C. § 301 *et seq.*, which provides health insurance for individuals aged at least 65 years and to certain disabled persons under the age of 65. Medicare is administered by the Centers for Medicare and Medicaid Services (“CMS”)¹ and funded through HHS.

7. Medicare includes coverage under two components: hospital insurance (Part A); and medical insurance (Part B). Coverage under Part B includes services rendered by doctors, outpatient hospital care and other medical services not covered by Part A. The Part B program is funded by premiums paid by Medicare beneficiaries enrolled in the program and is supplemented by contributions from funds provided and paid by the United States. Hospital claims for payment of Part B services, including diagnostic laboratory tests provided to Medicare beneficiaries, are processed by fiscal intermediaries. 42 U.S.C. § 1395h(a); 42 C.F.R. § 421.5(c). The fiscal intermediary currently under contract with CMS to process and pay Part B claims of eligible beneficiaries for services rendered by a hospital provider is Mutual of Omaha Insurance Company (“Mutual of Omaha”), located in Omaha, Nebraska. In June of 1997, Mutual of Omaha took over the administration of Medicare claims from Aetna Life Insurance, located in Fort Washington, Pennsylvania, who was the fiscal intermediary for Abington for at least ten years prior in time, including the period from 1991 through 1997.

8. The Part B Program pays claims for reimbursement submitted by or on behalf of Medicare beneficiaries for a portion of the reasonable charges of certain medical services, including certain outpatient clinical laboratory services, which are determined to be reasonable and necessary under §§ 1861(s) and 1842(a)(1) of the Social Security Act, 42 U.S.C. §§ 1395x(s) and 1395u (a)(1). CMS determines the types of services covered and therefore reimbursable

¹Prior to June 14, 2001, the Centers for Medicare Medicaid Services was named the Health Care Financing Administration (“HCFA”).

based upon a fee schedule.

9. Medicare assigns provider numbers to health care providers. The use of these provider numbers allows the health care providers to bill the fiscal intermediary or fiscal carrier directly for services rendered to patients who are eligible to receive medical services under the Part B Program.

10. In order to be paid for services rendered or supplies provided, a hospital provider who participates in the Medicare Part B Program submits claims for payment to the fiscal intermediary via either: (a) a hard copy "Request for Medicare Payment" form (Form HCFA 1450); or (b) an electronic submission. At the times relevant to this complaint, Abington submitted its claims to Medicare either electronically or via a hard copy of HCFA form 1450.

11. A claim for outpatient tests identifies the name of the Medicare beneficiary, the name of the referring physician, the date the service was provided, the CPT codes (defined below in paragraph 13) of the tests performed, and the ICD-9 number (diagnosis code) corresponding to the medical condition for which the test is needed.

12. Each outpatient laboratory test billed by a hospital to Medicare must be ordered in writing by a treating physician with a valid license, be medically necessary in the view of the treating physician for diagnosis or treatment of the patient's condition, be actually performed, and have the results of the tests recorded in laboratory records and reported to the treating physician. Hospital records must exist and be maintained to support each of the requirements set forth in this paragraph, but the records need not be provided to the Medicare intermediary unless specifically requested.

13. Health care providers for all federal health care benefit programs, including Medicare, use a uniform system of coding to report professional services, procedures, supplies

and diagnoses. Medical services are assigned a number and are listed in certain publications. The HCPCS system is a three-level system of coding developed by the then HCFA. "HCPCS" is the acronym that stands for Health Care Finance Administration Common Procedure Coding System. Level I of the HCPCS coding system is the American Medical Association's Physician's Current Procedural Terminology ("CPT") Codes. CPT codes are five-digit codes with descriptive terms for reporting services performed by health care providers. Outpatient clinical laboratory procedures are assigned a procedure code and are listed in the CPT codes. Fiscal intermediaries and providers often refer to CPT codes and HCPCS codes generally as HCPCS codes.

14. The Medicare claim submitted by the health care provider is the invoice relied upon by Medicare to pay the charges submitted by providers, including Abington, and by its own terms is for payment of services actually rendered.

15. At all times relevant to this complaint, Abington was a participating Medicare provider.

16. At all time relevant to this complaint, Abington was aware that Medicare relied initially on the provider's claims to authorize payment of Medicare funds for laboratory services.

NATURE OF THE FALSE OR FRAUDULENT CLAIMS

17. During the period of 1991 through 1999, Abington operated an outpatient clinical laboratory that, among other things, performed chemistry tests, that involved the measurement of various chemical levels in the blood; hematology tests, that were performed to count and measure blood cells and their content; and urinalysis tests, that examined urine sediment either with or without microscopy on Medicare beneficiaries.

Blood Chemistry Tests

18. Claims that were submitted by Abington both unbundled and duplicated chemistry laboratory charges, which were paid by the Fiscal Intermediary (“FI”). The FI’s system for processing hospital outpatient laboratory services contains a list of HCPCS codes assigned to blood chemistry tests, specified in the AMA’s CPT code book or by the hospital’s FI. These chemistry tests are frequently done as groups and combinations (“profiles”) on automated multichannel equipment. The CPT code book states that for any combination of tests among those listed, “use the appropriate number 80002 - 80019”, which are the codes used for a battery of tests performed on multichannel equipment. It was not proper to bill separately for two or more HCPCS codes (80002 - 80019), or to bill for individual tests where billing one charge for the battery of tests would be appropriate. From the period 1991 through 1994, HCFA required that these chemistry tests done as groups and/or individual automated multichannel chemistry tests, claimed for the same patient for the same date of service, be grouped together (bundled) for payment purposes. The Medicare Hospital Manual gave specific guidance with respect to automated battery of tests, e.g. chemical profiles. The Manual, at § 437 (J), under the heading of “Billing Procedures”, required that certain blood chemistry tests be bundled together and billed as one charge when those tests were performed simultaneously as “multi-channel automated and/or batch automated ... laboratory determinations.”

19. Abington’s billing practices caused the submission of claims which unbundled individual chemistry tests and/or automated batteries of tests. For example, for the same patient, same date of service, Abington billed as follows: (a) with two separate HCPCS codes (e.g. HCPCS code 80006 with HCPCS code 80012) instead of a single code (such as HCPCS code 80018) for which it would have been reimbursed for less; (b) with one or more HCPCS codes

used for a battery of tests and HCPCS codes for individual chemistry tests (e.g. HCPCS code 80004 with HCPCS code 84132 instead of a single code which would have included the single test, and for which it would have been reimbursed for less); or (c) combinations of the above. The submission of such claims by Abington, for tests that were unbundled for billing purposes, occurred over 33,000 times, during the period from 1991 through 1994, and caused Abington to be overpaid by Medicare by approximately \$275,000 during that period.

20. The Medicare guidelines state that services that are not reasonable and necessary for the diagnosis or treatment of illness or injury are not covered. In order for the tests to be reimbursable by Medicare for services, including outpatient laboratory diagnostic tests, the tests must be medically necessary and the charges reasonable. 42 U.S.C. § 1395y(a)(1)(A) clearly states that medically unnecessary services are not reimbursable, and 42 C.F.R. § 411.406 requires that providers comply with the rules and regulations. The primary responsibility for implementing this rule rests with the providers. Section 1156 of the Social Security Act instructs providers that “it shall be the obligation of any [provider] ... to assure” that services or items ordered or provided, will be supported by evidence of medical necessity and quality presented in such form and fashion and at such time as may be reasonably required. 42 U.S.C. § 1320c-5.

21. Upon information and belief, Abington submitted claims during the period from 1991 through 1997 that reflected the billing of chemistry tests that were not medically necessary in accordance with Medicare guidelines. The chemistry tests and their respective HCPCS codes include the following: Iron binding capacity (“IBC”) (HCPCS code 83550); and Iron (HCPCS code 83540). For instance, it is not ordinarily necessary to measure both iron/IBC (or transferrin) and ferritin in initial patient testing for most patients. If clinically indicated after evaluation of the initial iron studies, and where the physician specifically requests the test, it may be appropriate to

perform additional iron studies either on the initial specimen or on a subsequently obtained specimen.

22. The submission of claims by Abington, for tests that were not medically necessary, occurred over 10,000 times when both (IBC) and (Iron) were billed on the same day for the same patient during the period from 1991 through 1999, and caused Abington to be overpaid by Medicare.

Blood Counts

23. Abington submitted claims during the period from 1991 through 1997 which reflect double billing, unbundling or upcoding of certain hematology tests. CPT codes exist for individual components of blood counts as well as for common combinations of such tests (such as hematology profiles). Hematology profiles consist of a group of hematology tests performed on an automated basis. These profiles include such component tests as a hematocrit, hemoglobin, red and white blood cell counts, platelet count, differential white blood cell counts (manual or automated) and a number of standard and additional indices. The hematology tests include blood counts which are used to evaluate and diagnose disease relating to abnormalities of the blood or bone marrow. These include primary disorders such as anemia, leukemia, polycythemia, thrombocytosis and thrombocytopenia. When there is a combination code that describes the tests performed, then that code must be used rather than billing multiple separate codes. The blood count tests and/or hematology profiles that are the subject of this complaint, and their respective HCPCS codes, are described as follows:

HCPCS 85021	Blood count; hemogram, automated (RBC, WBC, Hgb, Hct, and indices only)
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HCPCS 85022	Blood count; hemogram, automated, and manual differential WBC count (CBC)
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HCPCS 85023	Blood count; hemogram and platelet count, automated, and manual differential WBC count (CBC)
HCPCS 85024	Blood count; hemogram and platelet count, automated, and automated partial differential WBC count (CBC)
HCPCS 85025	Blood count; hemogram and platelet count, automated, and automated complete differential WBC count(CBC)
HCPCS 85027	Blood count; hemogram and platelet count, automated
HCPCS 85595	Platelet, automated count

HCPCS code 85595 is described as “ Platelet; electronic technique” for the years prior to 1993.

The electronic technique is the same as an automated count.

24. Abington caused the submission of claims that showed unbundling of two hematology HCPCS codes. The component of tests represented in HCPCS codes 85021 and 85595, which Abington billed, are described in the combination code HCPCS code 85027. This billing occurred approximately 300 times for 1992, and Abington was overpaid by Medicare by approximately \$2,000.

25. Abington billed for a platelet count using HCPCS code 85595, with either HCPCS codes 85023, 85024, or 85025 which are complete blood counts (“CBC”). Each of the CBC profiles include a hemogram and differential white blood count (“WBC”). The hemogram includes the enumeration of red blood cells, white blood cells, and platelets, as well as the determination of hemoglobin, hematocrit, and indices. Thus, the platelet count is already included in the CBC procedures. The submission of these claims by Abington, which included double billing of platelet counts, occurred approximately 10,200 times during the period from 1991 through 1997 and caused Abington to be overpaid by Medicare by approximately \$67,817.00.

26. The hospital also billed for the same hematology services twice, for the same patient

on the same date of service. Double billing occurred when one or more of the following hematology profiles were billed at the same time: HCPCS codes 85021, 85023, 85024, 85025, 85027. The submission of these claims which included the double billing of hematology profiles by Abington, occurred approximately 400 times during the period from 1991 through 1997, and caused Abington to be overpaid by Medicare by approximately \$4,000.

27. For the period from 1991 through 1994, Abington billed HCPCS code 85025, a CBC including “complete” automated differential, a procedure more extensive than the one they were performing, a CBC including “partial” automated differential (designated as HCPCS code 85024.) The hospital placed into service a new Beckman Coulter lab analyzer in February, 1995. The new hematology equipment was capable of performing a “complete” automated or “5-part” white cell differential, unlike the hospital’s old equipment. The practice of billing for hematology tests using HCPCS code 85025 instead of HCPCS code 85024 was upcoding, or the billing of services at a higher level of care than actually rendered. Abington caused the submission of approximately 73,200 claims which included upcoding of hematology services, and Abington was overpaid by Medicare by approximately \$252,000.00.

Urinalysis Tests

28. Abington submitted claims during the period from 1991 through 1999 that reflected unbundling and double billing of certain HCPCS urinalysis codes. Urinalysis tests, with or without clinical microscopy tests, yield significant information about the patient, both in terms of differential diagnosis and by exclusion of many conditions when the urinalysis is “normal.” They also play a significant role in the diagnosis and management of renal diseases and other disease states. Laboratory Test Handbook, D.S. Jacobs et al, Lexi-Comp Inc, 4th edition. When a urinalysis test is ordered, there may be instances which warrant a microscopy examination

initially, such as diagnosis and/or treatment for urinary tract infection; or when the dip stick (chemical analysis) is positive or sediment shows crystals, cast or is cloudy. The propriety of the use of a particular urinalysis procedure code is dependent upon which technique was specified by the ordering physician as well as the codes that were available for use at the time the test was ordered. Although revisions to the descriptors were introduced in 1993 and in 1996, the relevant procedure codes were defined in 1996 as follows:

HCPCS 81000	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; with microscopy (<i>no change from 1993</i>).
HCPCS 81001	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; urinalysis, automated with microscopy (<i>code added in 1999</i>).
HCPCS 81002	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; without microscopy, non-automated.
HCPCS 81003	Urinalysis, without microscopy, automated (<i>no change from 1993</i>).
HCPCS 81005	Urinalysis; qualitative or semiquantitative, except immunoassays (<i>no change from 1993</i> .)
HCPCS 81015	Urinalysis; microscopic only (<i>no change from 1989</i>).

29. Abington billed either HCPCS code 81002 or 81003 with HCPCS code 81015, for the same patient, same date of service, resulting in unbundling of HCPCS code 81000, which is addressed in the Medicare Hospital Manual guidelines, “Billing Procedures” § 437 H. The submission of claims by Abington, which reflected unbundling of urinalysis codes, occurred approximately 11,215 times during the seven year period from 1993 through 1999, and caused Abington to be overpaid by Medicare by approximately \$35,000.00.

30. Abington double billed for urinalysis services by either billing for a test that was already included in another procedure code or by billing for the same urinalysis test twice. For instance, Abington submitted claims with HCPCS codes 81003 or 81005 billed along with HCPCS code 81000, which is duplicative billing of chemical testing, for the same patient, same date of service. Abington also submitted claims which contained HCPCS codes 81000, 81003 or 81005 more than once, for the same patient, same date of service. The double billing of urinalysis services occurred approximately 5,582 times during the period from 1991 through 1999, and caused Abington to be overpaid by Medicare by approximately \$18,000.00.

Low-Density Lipoprotein Cholesterol

31. Abington submitted claims for a component test of a lipid panel, the direct measurement of low-density lipoprotein cholesterol (“LDL”), which was not actually performed by the hospital. A lipid profile consists of a panel of tests involving serum lipids used to evaluate coronary heart disease risk. Lipid profiles usually include fasting serum, total cholesterol (HCPCS code 82465), triglycerides (HCPCS code 84478), high-density lipoprotein cholesterol (“HDL”) (HCPCS code 83718), direct measurement of low-density lipoprotein cholesterol (“LDL”) (HCPCS code 83721), or estimate (by calculation) of very-low lipoprotein cholesterol (“VLDL”) (HCPCS code 83720).

32. In early 1993, the editorial panel of the American Medical Association eliminated all separate codes for calculated values; only the codes for direct measurement of lipids (for example) are reported. The following CPT code was deleted in 1993:

Code 83720 Lipoprotein cholesterol fractionation calculation by formula.

Even though a provider may continue to calculate LDL cholesterol on a routine basis, no

payment is made by the Medicare program for calculating LDL levels. A direct measurement test for LDL cholesterol was first marketed in early 1993 and is identified with the following code:

Code 83721 Lipoprotein, direct measurement; LDL cholesterol.

This is not a routine screening test and should be used only when monitoring patient under treatment for high cholesterol. Further, HCPCS code 83721 should only be used when direct measurement lipoprotein, LDL cholesterol tests are performed. Medicare News Update, Issue #1996-1.

33. Abington billed for a service not rendered. After HCPCS code 83720 was deleted in early 1993, the hospital continued to calculate LDL cholesterol on a routine basis, and submitted claims with HCPCS code 83721 for the calculated LDL levels. Abington submitted claims with HCPCS code 83721, for the period from 1993 through 1996, even though they were not performing a direct measurement test for LDL cholesterol. Abington caused the submission of claims where direct measurement test for LDL cholesterol was billed over 17,000 times during the four year period. Because of the billing of a service not rendered, Abington was overpaid by Medicare by approximately \$220,000.

34. Attached as Exhibit 1 to this complaint is a sample of forty-five claims, representing each type of improper claims submission by Abington during the relevant time period, as described above in the paragraphs 17 through 33: multichannel unbundling; medical necessity of IBC and Iron; duplicate payment of hematology codes; double billing of platelet count; upcoding of blood count (automated differential); unbundling of urinalysis codes; double billing of urinalysis codes; and the non-performance of a direct measurement test for LDL cholesterol. The claims are

listed with patient number,² DCN Claim Number, Dates of Service, and HCPCS codes.

35. For each of the claims submitted, Abington knew at the time the claim was submitted that the claim was not correct and that the amount stated due was not true, or Abington submitted the claim in reckless disregard and/or deliberate ignorance of whether the claim was correct and the amount stated due was true.

36. Abington submitted, or caused to be submitted, the claims knowing that they were false and/or in reckless disregard or deliberate ignorance of their truth or falsity.

37. Each of the claims for payment is a false claim for payment from federal funds.

38. As a result of the submission of over 70,000 false claims, Medicare, through Aetna and then Mutual of Omaha, paid federal funds to Abington to which it was not entitled, and which Abington has retained, in the approximate sum of about \$1,000,000.00.

Defendant Kept Itself Deliberately Ignorant

39. During the period of 1991 through 1999, Abington failed to undertake any effective and/or appropriate inquiry into the accuracy of its claims submission process and program, failed to effectively audit its outpatient laboratory billings for chemistry, hematology and urinalysis tests to Medicare, failed to undertake appropriate sampling, or review of individual outpatient laboratory claims for chemistry, hematology and urinalysis tests, between 1991 and 1999, and failed to capture or consider billing complaints or denials by other payors. The failure to undertake any of these actions allowed Abington to keep itself deliberately ignorant of the truth or falsity of its billings to Medicare.

² In accordance with federal regulations governing patient privacy, the United States has redacted each beneficiary's Medicare HIC number from this Exhibit and assigned a simple numerical reference 1 - 45 for each Medicare beneficiary in the sample. For the sample claims previously provided to counsel for Abington, the information did include personal identifying data, including HIC number.

40. During the period from 1991 through 1997, the hospital did not have in place a Compliance Plan for its clinical laboratory. During 1998, Abington developed and implemented a Compliance Program which, among other things, was to ensure billing accuracy and compliance with Medicare, Medicaid and other federally funded health care regulations, guidelines and requirements imposed on clinical laboratories.

41. The Compliance Program failed to uncover any improper Medicare billings and payments with respect to the outpatient laboratory services which are the subject of this complaint.

42. Abington failed to refund any monies to the Medicare Trust Fund with respect to the improper billing and payments alleged in this complaint.

43. Abington, even with its compliance program, continued to submit improper bills to the fiscal intermediary, which are the subject of this complaint.

44. The United States, through the United States Attorney's Office, Eastern District of Pennsylvania ("USAO") notified Abington in a letter dated November 24, 2000 that it was conducting an on-going investigation of Medicare claims submitted for certain outpatient clinical laboratory services.

45. By that notification, the United States requested that Abington retain all records relating to the provision of and necessity for outpatient laboratory services, and the billing for such services, so that an assessment could be made as to whether or not Abington was improperly submitting claims for payment to the Medicare program.

46. The United States believes and avers that, after receipt of the request to preserve laboratory records, and after notice that certain laboratory billing practices by Abington were potentially improper, Abington failed to maintain and/or intentionally destroyed and/or disposed

of physician orders, billing and other records.

47. Abington's practice of destruction of records effectively prevented, and continues to prevent, a review of the physician orders for a determination of whether certain chemistry tests, including IBC and iron, performed and billed to Medicare were medically necessary.

48. The United States and Abington subsequently entered into a tolling agreement that tolled the Statute of Limitations set forth in the False Claims Act, 31 U.S.C. § 3729 et seq, or in 28 U.S.C. § 2416 - 2416 from December 7, 2000 until such time either party terminated the agreement upon fifteen days written notice. See Exhibit 2 attached to this Complaint. That tolling agreement, with its fifteen-day grace period, remains in effect until April 21, 2003. Thus, all of the False Claim Act claims asserted herein are timely.

49. Facts material to the United State's right of action for unjust enrichment and payment under mistake of fact against Abington were not known, and reasonably could not have been known by an official of the United States charged with the responsibility to act under the circumstances, at the earliest, prior to December 7, 1994. Thus, all of the unjust enrichment and payment under mistake of fact claims asserted herein are timely.

50. The United States, on September 8, 1999, initially requested copies of all Medical Assistance ("Medicaid") Audit Reports, relating to outpatient laboratory services provided by hospital providers in the Commonwealth of Pennsylvania. These reports, which included the audit of Abington, were provided to the United States at the DPW office in Harrisburg, on September 14, 1999. Included as part of the audit documents for Abington were the following: a letter dated September 23, 1993 from the Director of the Division of Provider Assessment to the Director of Business Services of Abington, which indicated "concerns" regarding the accuracy of coding for certain outpatient services; a detailed report prepared by Coopers & Lybrand ("C&L"), entitled

“Medicaid Review Summary” for Abington, dated July 27, 1994; and copies of an executed Settlement Agreement dated September 15, 1994 for the settlement amount of \$275,000.00.

51. Both the letter dated September 23, 1993 from the Director of the Division of Provider Assessment to the Director of Business Services of Abington, and C&L’s report addressed the submission of claims with inaccurate procedure codes, relating to: double billing of platelet count (the billing of HCPCS code 85595 with 85025, #14 on the 9/23/93 letter); hematology upcoding (whether the billing of HCPCS code 85025 “accurately reflects the service rendered”, #9 letter dated 9/23/93); unbundling of microscopic urinalysis (the billing of HCPCS codes 81002 and 81015, in lieu of HCPCS code 81000, #1 on the 9/23/93 letter); double billing of urinalysis with microscopy (HCPCS code 81003 with 81000, C&L report, page 12); unbundling of multichannel chemistry tests (examples include the billing of HCPCS code 80006 with 82947, C&L page 13; the billing of HCPCS code 80006 with 80002, C&L page 18). The accuracy of the coding of these same procedures by Abington, and its subsequent submission of fraudulent claims to Medicare, are addressed in this complaint.

52. Through the results of this Medicaid Audit, The Commonwealth of Pennsylvania notified Abington almost eight years ago that it was improperly billing for outpatient laboratory tests due to unbundling of blood chemistry (automated multichannel) tests, double billing of platelets, upcoding or billing for hematology tests not performed, and, double billing and unbundling of certain urinalysis procedures.

53. The failings pointed out by the Commonwealth of Pennsylvania with respect to Abington’s Medicaid outpatient billings should have placed Abington on notice that the same or similar failings were present in its billings for outpatient laboratory services for Medicare.

54. When Abington discovered the improper Medicaid billings and payments, for the

period 1991 through 1994, it failed to properly remedy all the systematic, personnel or operational problems in order to correct for the improper billings for Medicare. Abington continued to double bill to Medicare for platelets through 1997, and unbundle codes for urinalysis services through 1999, three and five years later, respectively. The failure to undertake any of these corrective actions allowed Abington to continue to submit false claims to Medicare.

55. Even after Abington repaid DPW for certain outpatient laboratory billings in 1995, Abington failed to disclose to the Medicare authorities the possibility of similar outpatient laboratory billings to Medicare. Abington knowingly continued to bill improperly, and to submit false claims for Medicare services. Abington failed to refund to the United States any monies it received from its false billings.

COUNT I
FALSE CLAIMS ACT

56. The United States re-alleges paragraphs 1 through 55 above as if fully set forth herein.

57. Abington knowingly submitted or caused the submission of false or fraudulent claims to Medicare for payment using federal funds between December 7, 1994 and December 31, 1999.

58. Each of the claims submitted, over 70,000 by Abington, is a separate false claim against federal funds.

COUNT II
UNJUST ENRICHMENT

59. The United States re-alleges paragraphs 1 through 58 above as if fully set forth

herein.

60. Abington has been unjustly enriched by its course of conduct as alleged in this complaint between January 1, 1991 and December 31, 1999 to the detriment of the United States.

COUNT III
PAYMENT BY A MISTAKE OF FACT

61. The United States re-alleges paragraphs 1 through 60 above as if fully set forth herein.

62. As a result of Abington's conduct, it was paid federal funds from the United States Treasury that were not properly payable.

63. At the time that such payments were made, the United States was not aware of Abington's wrongful conduct. Had the United States known that Abington was not entitled to receive payments, it would not have approved payment of such funds.

64. The United States is entitled to recover those funds paid by mistake on account of Abington's conduct between January 1, 1991 and December 31, 1999.

WHEREFORE, the United States respectfully requests judgment against the Defendant as follows:

A. On Count I for judgment against the Defendants and in favor of the United States for treble its damages, and for a civil penalty for each false claim submitted to Medicare and for each false record or statement made, as allowed by law.

B. On Counts II & III for judgment against the Defendants and in favor of the United States for its damages, prejudgment and post judgment interest, costs and other proper relief.

Respectfully Submitted,

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Dated: April 21, 2003